		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0031690

Facility Name: Sullivan Health Care Center

Address: 11 Hawthorne Street (Number) Sullivan (City) 61951 (Zip Code)

County: Moultrie

Telephone Number: (217) 728-4327 **Fax #** (217) 7282263

IDPA ID Number: 51-0271905

Date of Initial License for Current Owners:

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steven D. Tenhouse, Olive LLP **Telephone Number:** (217) 753-1375

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/99 to 06/30/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) Chad Butterfield, THCSLLC, Mgt. Co. for
(Title) Sullivan Health Care Center

Paid Preparer
(Signed) (Date)
(Print Name and Title) Olive LLP
(Firm Name & Address) 205 S. 5th Street, Suite 645, Springfield, IL 62701
(Telephone) (217) 753-1375 Fax # (217) 744-0193

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sullivan Health Care Center # 0031690 Report Period Beginning: 07/01/99 Ending: 06/30/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	123	Skilled (SNF)	123	45,018	1
2	0	Skilled Pediatric (SNF/PED)	0	0	2
3	0	Intermediate (ICF)	0	0	3
4	0	Intermediate/DD	0	0	4
5	0	Sheltered Care (SC)	0	0	5
6	0	ICF/DD 16 or Less	0	0	6
7	123	TOTALS	123	45,018	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	638	11	1,661	2,310	8
9	SNF/PED	0	0	0		9
10	ICF	10,782	6,090	17	16,889	10
11	ICF/DD	0	0	0		11
12	SC	0	0	0		12
13	DD 16 OR LESS	0	0	0		13
14	TOTALS	11,420	6,101	1,678	19,199	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 42.65%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Y

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/18/86

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/18/86 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 12 and days of care provided 1,661

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30 Fiscal Year: 6/30

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sullivan Health Care Center # 0031690 Report Period Beginning: 07/01/99 Ending: 06/30/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	93,261	8,350	5,685	107,296		107,296	(508)	106,788			1
2	Food Purchase		96,955		96,955		96,955	(1,338)	95,617			2
3	Housekeeping	53,297	12,713		66,010		66,010		66,010			3
4	Laundry	30,410	8,833		39,243		39,243		39,243			4
5	Heat and Other Utilities			108,435	108,435		108,435	6	108,441			5
6	Maintenance	24,881	4,288	24,254	53,423		53,423		53,423			6
7	Other (specify):*			3,347	3,347		3,347		3,347			7
8	**TOTAL General Services**	201,849	131,139	141,721	474,709		474,709	(1,840)	472,869			8
	B. Health Care and Programs											
9	Medical Director			13,970	13,970		13,970		13,970			9
10	Nursing and Medical Records	656,091	35,854	1,190	693,135		693,135		693,135			10
10a	Therapy											10a
11	Activities	29,135	1,944	2,639	33,718		33,718		33,718			11
12	Social Services	23,276	39	1,892	25,207		25,207		25,207			12
13	Nurse Aide Training					4,626	4,626		4,626			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	708,502	37,837	19,691	766,030	4,626	770,656		770,656			16
	C. General Administration											
17	Administrative	48,338			48,338		48,338		48,338			17
18	Directors Fees											18
19	Professional Services			151,472	151,472		151,472	12,519	163,991			19
20	Dues, Fees, Subscriptions & Promotions			59,575	59,575		59,575	(17,988)	41,587			20
21	Clerical & General Office Expenses	61,731	19,734	85,054	166,519		166,519	(61,463)	105,056			21
22	Employee Benefits & Payroll Taxes			149,840	149,840		149,840		149,840			22
23	Inservice Training & Education			5,242	5,242	(4,626)	616		616			23
24	Travel and Seminar			4,812	4,812		4,812	518	5,330			24
25	Other Admin. Staff Transportation			4,091	4,091		4,091		4,091			25
26	Insurance-Prop.Liab.Malpractice			44,928	44,928		44,928	1,052	45,980			26
27	Other (specify):*											27
28	**TOTAL General Administration**	110,069	19,734	505,014	634,817	(4,626)	630,191	(65,362)	564,829			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,020,420	188,710	666,426	1,875,556		1,875,556	(67,202)	1,808,354			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Sullivan Health Care Center #0031690 Report Period Beginning: 07/01/99 Ending: 06/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			131,019	131,019		131,019	12,859	143,878			30
31	Amortization of Pre-Op. & Org.			12,080	12,080		12,080	(12,080)	0			31
32	Interest			417,354	417,354		417,354	(6,710)	410,644			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,650	1,650		1,650	43	1,693			35
36	Other (specify):*											36
37	**TOTAL Ownership**			562,103	562,103		562,103	(5,888)	556,215			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		45,267	122,793	168,060		168,060	(92)	167,968			39
40	Barber and Beauty Shops							(405)	(405)			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			67,527	67,527		67,527		67,527			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		45,267	190,320	235,587		235,587	(497)	235,090			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,020,420	233,977	1,418,849	2,673,246		2,673,246	(73,587)	2,599,659			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sullivan Health Care Center # 0031690 Report Period Beginning: 07/01/99 Ending: 06/30/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(508)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients	(92)	39		7
8	Laundry for Non-Patients		4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(5,349)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		32		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(8,101)	21		18
19	Entertainment				19
20	Contributions		21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(25,000)	21		24
25	Fund Raising, Advertising and Promotional	(17,988)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	10,486			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (46,552)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense	(12,080)	31	33
34	Adjustments for Related Organization Costs (Schedule VII)	(14,955)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (27,035)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (73,587)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Sullivan Health Care Center

ID# 0031690

Report Period Beginning: 07/01/99

Ending: 06/30/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vendor Income	$ 0	1	1
2	Barber and Beauty Revenue	(405)	40	2
3	Extraordinary Income/(Expense)			3
4	(Gain)/Loss on Sale of Assets	0	30	4
5	Miscellaneous (Income)/Expense	0	21	5
6	Adjust Depreciation Expense to Schedule XI	12,859	30	6
7	Raw foods rebate	(1,338)	2	7
8	Offset bank fees	(630)	21	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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78				78
79				79
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81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	10,486		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sullivan Health Care Center # 0031690 Report Period Beginning: 07/01/99 Ending: 06/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(508)	0	0	0	0	0	0	0	0	0	0	(508)	1
2	Food Purchase	(1,338)	0	0	0	0	0	0	0	0	0	0	(1,338)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	6	0	0	0	0	0	0	0	0	0	6	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,846)	6	0	0	0	0	0	0	0	0	0	(1,840)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	12,519	0	0	0	0	0	0	0	0	0	12,519	19
20	Fees, Subscriptions & Promotions	(17,988)	0	0	0	0	0	0	0	0	0	0	(17,988)	20
21	Clerical & General Office Expenses	(33,731)	(27,732)	0	0	0	0	0	0	0	0	0	(61,463)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	518	0	0	0	0	0	0	0	0	0	518	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	1,052	0	0	0	0	0	0	0	0	0	1,052	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(51,719)	(13,643)	0	0	0	0	0	0	0	0	0	(65,362)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(53,565)	(13,637)	0	0	0	0	0	0	0	0	0	(67,202)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sullivan Health Care Center # 0031690 **Report Period Beginning:** 07/01/99 **Ending:** 06/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	12,859	0	0	0	0	0	0	0	0	0	0	12,859	30
31	Amortization of Pre-Op. & Org.	(12,080)	0	0	0	0	0	0	0	0	0	0	(12,080)	31
32	Interest	(5,349)	(1,361)	0	0	0	0	0	0	0	0	0	(6,710)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	43	0	0	0	0	0	0	0	0	0	43	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(4,570)	(1,318)	0	0	0	0	0	0	0	0	0	(5,888)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(92)	0	0	0	0	0	0	0	0	0	0	(92)	39
40	Barber and Beauty Shops	(405)	0	0	0	0	0	0	0	0	0	0	(405)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(497)	0	0	0	0	0	0	0	0	0	0	(497)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(58,632)	(14,955)	0	0	0	0	0	0	0	0	0	(73,587)	45

Facility Name & ID Number Sullivan Health Care Center # 0031690 Report Period Beginning: 07/01/99 Ending: 06/30/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		See Attached Listing				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Heat and Other Utilities	$	MidAmerica Care Foundation	100.00%	$ 6	$ 6	1
2	V	19	Professional Services		MidAmerica Care Foundation	100.00%	12,519	12,519	2
3	V	21	Clerical & Other General Office	27,871	MidAmerica Care Foundation	100.00%	139	(27,732)	3
4	V	24	Travel and Seminar		MidAmerica Care Foundation	100.00%	518	518	4
5	V	26	Insurance		MidAmerica Care Foundation	100.00%	1,052	1,052	5
6	V	32	Interest Expense		MidAmerica Care Foundation	100.00%	(1,361)	(1,361)	6
7	V	35	Rent-Equipment		MidAmerica Care Foundation	100.00%	43	43	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 27,871			$ 12,916	$ * (14,955)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sullivan Health Care Center # 0031690 Report Period Beginning: 07/01/99 Ending: 06/30/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Michael A. Michaud	Director	President	0.00				BOD Fees	$ 675	Ln 19, Col. 3	1
2	W. Terrence Brown	Director	Secretary	0.00				BOD Fees	675	Ln 19, Col. 3	2
3	Edward T. Weaver	Director	Treasurer	0.00				BOD Fees	675	Ln 19, Col. 3	3
4	Donald A. Udstuen	Director						BOD Fees	675	Ln 19, Col. 3	4
5	Michael F. Flanagan		Asst. Secretary	0.00				BOD Fees			5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 2,701		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Sullivan Health Care Center # 0031690 Report Period Beginning: 07/01/99 Ending: 06/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MidAmerica Care Foundation
Street Address: 7611 State Line Road, Suite 301
City / State / Zip Code: Kansas City, Missouri 64114
Phone Number: (816) 444-0900
Fax Number: (816) 822-8799

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Heat and Other Utilities	Patient Days	405,210	13	$ 121	$	19,199	$ 6	1
2	19	Professional Services	Patient Days	405,210	13	264,226		19,199	12,519	2
3	21	Clerical & Other General Office	Patient Days	405,210	13	2,944		19,199	139	3
4	24	Travel and Seminar	Patient Days	405,210	13	10,926		19,199	518	4
5	26	Insurance	Patient Days	405,210	13	22,213		19,199	1,052	5
6	32	Interest Expense	Patient Days	405,210	13	(28,728)		19,199	(1,361)	6
7	35	Rent-Equipment	Patient Days	405,210	13	912		19,199	43	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 272,614	$		$ 12,916	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sullivan Health Care Center # 0031690 Report Period Beginning: 07/01/99 Ending: 06/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Sullivan Class 5(G) Bonds		X	Mortgage	Varies	12/1/86	$ 3,685,000	$ 3,981,360	11/01/15	10.00%	$ 407,471	1
2	Moultrie County Treasurer		X	Past Due R/E Taxes	Varies	4/1/91	188,072	89,143	04/01/06	9.00%	9,882	2
3												3
4												4
5												5
	Working Capital											
6	Interest Income		X								(5,349)	6
7	H/O Interest Income	X									(1,361)	7
8												8
9	TOTAL Facility Related						$ 3,873,072	$ 4,070,503			$ 410,643	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,873,072	$ 4,070,503			$ 410,643	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sullivan Health Care Center **#** 0031690 **Report Period Beginning:** 07/01/99 **Ending:** 06/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995		8
1996		9
1997		10
1998		11
1999		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.** **This denial must be no more than four years old at the time the cost report is filed.**

Facility Name & ID Number Sullivan Health Care Center # 0031690 Report Period Beginning: 07/01/99 Ending: 06/30/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,000 B. General Construction Type: Exterior Brick and block Frame _____ Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 373,435
2. Number of Years Over Which it is Being Amortized: Various
3. Current Period Amortization: 12,080
4. Dates Incurred: Various

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home			$ 10,000	1
2					2
3	TOTALS			$ 10,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sullivan Health Care Center # 0031690 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	123		86	75	$ 2,445,879	$ 81,529	30	$ 81,529	$ (0)	$ 1,107,440	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Improvements 1987			87	273,428	9,284	29	9,429	145	121,068	9
10	Improvements 1989			89	12,690	846	15	846		10,434	10
11	Improvements 1990			90	290		7			262	11
12	Improvements 1991			91	59,830	448	7	8,547	8,099	57,113	12
13	Improvements 1992			92	12,364	38	7	1,766	1,728	12,364	13
14	Improvements 1993			93	45,257	6,115	7	6,465	350	44,789	14
15	Improvements 1994			94	39,875	4,187	10	3,988	(200)	25,450	15
16	Improvements 1995			95	33,875	3,551	10	3,388	(164)	17,219	16
17	Improvements 1996			96	59,078	4,547	20	2,954	(1,593)	17,210	17
18	Painting and Wall Border			97	170	6	30	6	(0)	19	18
19	Grease Trap			97	1,502	75	20	75	(0)	250	19
20	Hopper with Trim			97	2,095	105	20	105		340	20
21	Repair Rubber Roof			97	12,509	1,251	10	1,251	0	4,065	21
22	Med Room Remodel			97	2,379	119	20	119	(0)	416	22
23	Compressor			97	949	136	7	136	(0)	452	23
24	Water Heater - 120 Gal			98	3,300	330	10	330		578	24
25	3 Water Heaters			98	10,200	1,020	10	1,020		2,380	25
26	Canopy at Front Entrance			99	5,274	322	15	352	29	322	26
27	Shower Remodel			99	24,162	1,208	15	1,611	403	1,208	27
28	Bathroom Remodel			99	4,330	265	15	289	24	265	28
29	6 Heat/AC Units			97	4,511	902	5	902	0	2,405	29
30	Compressor - A/C			98	1,148	77	15	77	(0)	147	30
31	Booster Heater			99	900	90	10	90		128	31
32	Booster Heater/Dishwasher			99	629	63	5	126	63	89	32
33	Parking Lot - Concrete			99	25,884	1,582	15	1,726	144	1,582	33
34	Electric Heater in shower room			99	243	49	5	49	(0)	69	34
35											35
36	TOTAL (lines 4 thru 35)				$ 3,082,750	$ 118,144		$ 127,172	$ 9,028	$ 1,428,064	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sullivan Health Care Center # 0031690 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sullivan Health Care Center # 0031690 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
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24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sullivan Health Care Center # 0031690 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sullivan Health Care Center # 0031690 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sullivan Health Care Center # 0031690 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 268,677	$ 11,357	$ 14,973	$ 3,616	20	$ 225,015	37
38	Current Year Purchases	17,332	1,517	1,733	216	10	1,517	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 286,009	$ 12,874	$ 16,706	$ 3,832		$ 226,532	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 3,378,759	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 131,018	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 143,878	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 12,860	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,654,596	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58	WIP	$ 1,050	58
59			59
60			60
61		$ 1,050	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Sullivan Health Care Center # 0031690 Report Period Beginning: 07/01/99 Ending: 06/30/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 1,650 Description: See attached detail
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sullivan Health Care Center # 0031690 Report Period Beginning: 07/01/99 Ending: 06/30/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$ 722	$ 3,609	$	$ 4,331
2	Books and Supplies	49	246		295
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$ 771	$ 3,855	$	$ 4,626
10	SUM OF line 9, col. 1 and 2 (e)	$ 4,626			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	15
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	3
2. From other facilities (f)	
TOTAL TRAINED	18

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$	1,693	$	33,867	$ 334	1,693	$ 34,202	1
2	Licensed Speech and Language Development Therapist		hrs		190		4,169	0	190	4,169	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs		4,240		63,596	0	4,240	63,596	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			$	6,123	$	101,633	$ 334	6,123	$ 101,967	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sullivan Health Care Center # 0031690 Report Period Beginning: 07/01/99 Ending: 06/30/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 112,265	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	208,196		3
4	Supply Inventory (priced at)	10,981		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 331,442	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	55,289		13
14	Buildings, at Historical Cost	2,992,837		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	331,684		16
17	Accumulated Depreciation (book methods)	(1,829,718)		17
18	Deferred Charges	373,435		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	14,867		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,938,394	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,269,836	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 55,487	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	3,772,509		29
30	Accrued Salaries Payable	75,669		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other liab.'s and Patient Trust Dep	18,843		36
37	Due to affiliates			37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,922,508	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	89,143		39
40	Mortgage Payable	3,981,360		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,070,504	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,993,011	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (5,723,175)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,269,836	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Sullivan Health Care Center # 0031690 Report Period Beginning: 07/01/99 Ending: 06/30/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (4,913,359)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (4,913,359)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(809,818)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)	2	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (809,816)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (5,723,175)	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sullivan Health Care Center # 0031690 Report Period Beginning: 07/01/99 Ending: 06/30/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,927,282	1
2	Discounts and Allowances for all Levels	(366,328)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,560,954	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	259,251	6
7	Oxygen	13,988	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 273,239	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	405	13
14	Non-Patient Meals	508	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	92	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,005	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,349	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,349	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Extraordinary Income/Loss & Misc.	22,881	28
28a	G/L on Sale of Asset		28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 22,881	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,863,428	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	474,709	31
32	Health Care	766,030	32
33	General Administration	634,817	33
	B. Capital Expense		
34	Ownership	562,103	34
	C. Ancillary Expense		
35	Special Cost Centers	168,060	35
36	Provider Participation Fee	67,527	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,673,246	40
41	**Income before Income Taxes (line 30 minus line 40)****	(809,818)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (809,818)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Yes **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Sullivan Health Care Center # 0031690 Report Period Beginning: 07/01/99 Ending: 06/30/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	4,858	5,238	$ 90,394	$ 17.26	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	2,639	2,798	51,490	18.40	3
4	Licensed Practical Nurses	13,278	13,740	211,679	15.41	4
5	Nurse Aides & Orderlies	32,384	33,240	295,356	8.89	5
6	Nurse Aide Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	0	0			8
9	Activity Director	2,974	3,042	29,135	9.58	9
10	Activity Assistants	0	0	0		10
11	Social Service Workers	2,946	3,032	23,276	7.68	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	13,477	14,267	93,261	6.54	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	2,213	2,242	24,881	11.10	17
18	Housekeepers	8,233	8,344	53,297	6.39	18
19	Laundry	4,494	4,699	30,410	6.47	19
20	Administrator	2,060	2,095	48,338	23.07	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	0	0	0		22
23	Office Manager	0	0	0		23
24	Clerical	4,373	5,124	61,731	12.05	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	1,103	1,105	7,171	6.49	31
32	Other Health Care(specify)	0	0	0		32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	95,032	98,966	$ 1,020,420 *	$ 10.31	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	151	$ 5,685	line 1, col 3	35
36	Medical Director	197	13,970	line 9, col 3	36
37	Medical Records Consultant			line 10, col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	84	1,190	line 10, col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	32	1,977	line 11, col 3	44
45	Social Service Consultant	40	1,892	line 12, col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	504	$ 24,714		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	Ln 10, Col 1	50
51	Licensed Practical Nurses	223	10,247	Ln 10, Col 1	51
52	Nurse Aides	40	3,797	Ln 10, Col 1	52
53	TOTAL (lines 50 - 52)	263	$ 14,044		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Sullivan Health Care Center # 0031690 Report Period Beginning: 07/01/99 Ending: 06/30/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Russell, Cindy	Administrator		$ 48,338
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 48,338

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Various	Purch Serv	$ 1,065
Tutera Health Care Mgt	Management Fees	102,194
Various	Legal Fees	14,693
Various	Accounting Fees	16,020
Various	D/P Fees	6,884
Various	Professional Serv	2,375
Various	Trustee Expenses	8,241
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 151,472

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 25,960
Unemployment Compensation Insurance	48,005
FICA Taxes	63,266
Employee Health Insurance	9,308
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	3,301
Home Office Allocation	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 149,840

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 365
Advertising: Employee Recruitment	31,101
Health Care Worker Background Check	3,143
(Indicate # of checks performed 262)	
Dues & Subscriptions	6,396
Advertising PR & Other	18,570
Reclassifications	0
Less: Public Relations Expense	( )
Non-allowable advertising	(17,988)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 41,587

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	4,812
Home Office Allocation	518
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,330

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Sullivan Health Care Center # 0031690 Report Period Beginning: 07/01/99 Ending: 06/30/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sullivan Health Care Center # 0031690 **Report Period Beginning:** 07/01/99 **Ending:** 06/30/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? N

(2) Are there any dues to nursing home associations included on the cost report? N
If YES, give association name and amount. 0

(3) Did the nursing home make political contributions or payments to a political action organization? N If YES, have these costs been properly adjusted out of the cost report? 0

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? Y If YES, what is the capacity? 86

(5) Have you properly capitalized all major repairs and equipment purchases? Y
What was the average life used for new equipment added during this period? 7 Years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 0 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Y If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? N
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES N NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO N If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 67,527
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? N If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Y

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? N For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? Y Indicate the amount. $ 508

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? N
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? N If YES, please indicate the amount of income earned from such a program during this reporting period. $ 0
c. What percent of all travel expense relates to transportation of nurses and patients? 0%
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Y
g. Does the facility transport residents to and from day training? N
Indicate the amount of income earned from providing such transportation during this reporting period. $ 0

(17) Has an audit been performed by an independent certified public accounting firm? Y
Firm Name: Donnelly, Meiners, Jordan & Kline The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N If no, please explain. Not yet completed

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Y

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? Y
Attach invoices and a summary of services for all architect and appraisal fees.